471-000-56 Nebraska Medicaid Billing Instructions for Hearing Aid Services

The instructions in this appendix apply when billing Nebraska Medicaid, also known as the Nebraska Medical Assistance Program (NMAP), for Medicaid-covered services provided to clients who are eligible for fee-for-service Medicaid or enrolled in the Nebraska Health Connection Medicaid managed care plan Primary Care +. Medicaid regulations for hearing aid services are covered in 471 NAC 8-000.

Claims for services provided to clients enrolled in a Nebraska Medicaid managed care health maintenance organization plan (e.g., Share Advantage) must be submitted to the managed care plan according to the instructions provided by the plan.

**Third Party Resources:** Claims for services provided to clients with third party resources (e.g., Medicare, private health/casualty insurance) must be billed to the third party payer according to the payer's instructions. After the payment determination by the third party payer is made, the provider may submit the claim to Nebraska Medicaid. A copy of the remittance advice, explanation of benefits, denial, or other documentation from the third party resource must be submitted with the claim.

**Verifying Eligibility:** Medicaid eligibility, managed care participation, and third party resources may be verified from –

1. The client's monthly Nebraska Medicaid Card or Nebraska Health Connection ID Document. For explanation and examples, see 471-000-123;
2. The Nebraska Medicaid Eligibility System (NMES) voice response system. For instructions, see 471-000-124; or
3. The standard electronic Health Care Eligibility Benefit Inquiry and Response transaction (ASC X12N 270/271). For electronic transaction submission instructions, see 471-000-50.

## CLAIM FORMATS

**Electronic Claims**: Hearing aid services are billed to Nebraska Medicaid using the standard electronic Health Care Claim: Professional transaction (ASC X12N 837). For electronic transaction submission instructions, see 471-000-50.

**Paper Claims:** Hearing aid services are billed to Nebraska Medicaid on Form CMS-1500, "Health Insurance Claim Form." Instructions for completing Form CMS-1500 are in this appendix. The CMS-1500 claim form may be purchased from the U. S. Government Printing Office, Superintendent of Documents, Washington, D.C. 20402 or from private vendors.

**Share of Cost Claims:** Certain Medicaid clients are required to pay or obligate a portion of their medical costs due to excess income. These clients receive Form EA-160, "Record of Health Cost – Share of Cost – Medicaid Program" from the local HHS office to record services paid or obligated to providers. For an example and instructions on completing this form, see 471-000-79.

## MEDICAID CLAIM STATUS

The status of Nebraska Medicaid claims can be obtained by using the standard electronic Health Care Claim Status Request and Response transaction (ASC X12N 276/277). For electronic transaction submission instructions, see 471-000-50.

Providers may also contact Medicaid Inquiry at 1-877-255-3092 or 471-9128 (in Lincoln) from 8:00 a.m. to 5:00 p.m. Monday through Friday.

## CMS-1500 FORM COMPLETION AND SUBMISSION

**Mailing Address:** When submitting claims on Form CMS-1500, retain a duplicate copy and mail the ORIGINAL form to –

Medicaid Claims Processing
Health and Human Services Finance and Support
P. O. Box 95026
Lincoln, NE 68509-5026

**Claim Adjustments and Refunds:** See 471-000-99 for instructions on requesting adjustments and refund procedures for claims previously processed by Nebraska Medicaid.

**Claim Example:** See 471-000-58 for an example of Form CMS-1500.

**Claim Form Completion Instructions:** The numbers listed below correspond to the numbers of the fields on the form. Completion of fields identified with an asterisk (*) is mandatory for claim acceptance. Information in fields without an asterisk is required for some aspect of claims processing/resolution. Fields that are not listed are not needed for Nebraska Medicaid claims.

*1a. INSURED'S I.D. NUMBER: Enter the Medicaid client's complete eleven-digit identification number (Example: 123456789-01). When billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child, enter the Medicaid number of the unborn child (see 471 NAC 1-002.02K).

*2. PATIENT'S NAME: Enter the full name (last name, first name, middle initial) of the person that received services.

*3. PATIENT'S BIRTHDATE AND SEX: Enter the month, day, and year of birth of the person that received the services. Check the appropriate box (M or F).

4. INSURED'S NAME: Complete only when billing for pregnancy-related services provided to the ineligible mother of an eligible unborn child. Enter the Medicaid client's name as it appears on the Nebraska Medicaid Card. This is the name of the person (the unborn child) whose number appears in Field 1a.

9. – 14. Fields 9–11 and 14 address third party resources other than Medicaid or Medicare. If there is no known insurance coverage, leave blank. If the client has insurance coverage other than Medicaid or Medicare, complete fields 9-11 and 14. A copy of the remittance advice, explanation of benefits, denial, or other documentation is required and must be attached to the claim. Nebraska Medicaid must review all claims for possible third party reimbursement. All third party resources must be exhausted before Medicaid payment may be issued.

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: Enter the name of the referring/prescribing physician.

*17a. I.D. NUMBER OF REFERRING PHYSICIAN: Enter the license number of the referring/prescribing physician listed in Field 17. License number listings are available from the Medicaid Division. License numbers may also be accessed on the HHS web site: www.hhs.state.ne.us/med/medindex.htm. Click on "Pharmacy Program."

21. DIAGNOSIS OR NATURE OF ILLNESS OF INJURY: The services on this claim form must be related to the diagnosis entered in this field. Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis codes.

The COMPLETE diagnosis code is required. (A complete code may include the third, fourth, and fifth digits, as defined in ICD-9-CM). If there is more than one diagnosis, list the primary diagnosis first.

22. MEDICAID RESUBMISSION: Leave blank. For regulations regarding resubmittal or adjustment requests, see 471 NAC 3-000 and 471-000-99.

23 PRIOR AUTHORIZATION NUMBER: Leave blank. Refer to Field 24k.

*24. Only six line items can be entered in Field 24. Do not print more than one line of information on each claim line. DO NOT LIST services for which there is no charge.

*24A. DATE(S) OF SERVICE: Enter the 8-digit numeric date of service rendered. Each procedure code/service billed requires a date.

*24B. PLACE OF SERVICE: Enter the place of service code 11 (office). National place of service codes are defined by the Centers for Medicare and Medicaid Services (CMS) and published on the CMS web site at http://www.cms.hhs.gov.

*24D. PROCEDURES, SERVICES, OR SUPPLIES: Enter the appropriate national HCPCS procedure code and, if required, procedure code modifier.

*Procedure Codes*: HCPCS procedure codes and procedure code modifiers used by Nebraska Medicaid are listed in the Nebraska Medicaid Practitioner Fee Schedule (see 471-000-508). Local procedure codes W0220 – W0223 are not valid with dates of service beginning October 16, 2003.

When using miscellaneous and not otherwise classified (NOC) procedure codes, a complete description of the service is required on or as an 8 ½ x 11 attachment to the claim.

*Procedure Code Modifiers*: Up to four modifiers may be entered for each procedure code. Procedure code modifier RP is required with procedure code V5160 and V5241 when the service is repair or replacement.

24E. DIAGNOSIS CODE: Enter the ICD-9-CM diagnosis code or list the reference number of the diagnoses indicated in field 21.

*24F. $ CHARGES: Enter the lab invoice cost for hearing aids and hearing aid repairs. Enter the fee schedule maximum allowable fee for dispensing fees. Enter your customary charge for other procedures. Do not list one charge for several procedure codes.

*24G. DAYS OR UNITS: Enter the number of services being claimed. If the procedure code description includes specific time or quantity increments, each increment should be billed as one unit of service.

NOTE: Batteries are billed per battery not per package of batteries. Medicaid allows a maximum of 16 batteries per aid dispensed on a date of service.

*24K. RESERVED FOR LOCAL USE

If the service requires prior authorization, enter the prior authorization number. This number must be entered to receive payment for a service or supply that requires prior authorization. Prior authorization requirements for hearing aid services are contained in 471 NAC 8-004.01.

If the service does not require prior authorization, leave blank.

*25. FEDERAL TAX I.D. NUMBER: Leave blank.

26. PATIENT'S ACCOUNT NO.: Optional. Any patient account information (numeric or alpha) may be entered in this field to enhance patient identification. This information will appear on the Medicaid Remittance Advice.

*28. TOTAL CHARGE: Enter the total of all charges in Field 24, Column F. If more than one claim form is used to bill for services provided, EACH claim form must be submitted with the line items totaled. DO NOT carry charge forward to another claim form.

*29. AMOUNT PAID: Enter any payments made, due, or obligated from other sources for services listed on this claim. Other sources may include health insurance, liability insurance, excess income, etc. A copy of the Medicare or insurance remittance advice, explanation of benefits, denial, or other documentation must be attached. DO NOT enter previous Medicaid payments, copayment or the difference between the provider's billed charge and the Medicaid allowable (provider "write-off" amount) in this field.

*30. BALANCE DUE: Enter the balance due. (This amount is determined by subtracting the amount paid in Field 29 from the total charge in Field 28.)

*31. SIGNATURE OF PHYSICIAN OR SUPPLIER: The provider or authorized representative must SIGN and DATE the claim form. A signature stamp computer generated or typewritten signature will be accepted.

The signature date must be on or after the date(s) of service listed on the form.

*33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #: Enter the provider's name, address, zip code, and phone number.

PIN NUMBER: Leave blank.

GRP NUMBER: Enter the eleven-digit Nebraska Medicaid provider number as assigned by Nebraska Medicaid (example: 123456789-12). All payments are made to the name and address listed on the Medicaid provider agreement for this provider number.

**Claim Attachments:** A copy of the purchase invoice must be attached to claims for hearing aids and miscellaneous services.